

4633
CERTIFICATE OF DEATH

Reg. Dist. No. 114

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>3 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Queen Ann Avenue</u>				STREET ADDRESS (If rural give location) <u>Queen Ann Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MILDRED SMITH ALDRIDGE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 26 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>4-23-1906</u>	
				9. AGE last birthday <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bookkeeper</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Appliance Store</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Edward T. Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha Phillips</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT & ADDRESS: <u>Mrs. James C. Johnson : Cambridge, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>LYMPHOMA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 YEARS</u>			
ANTECEDENT CAUSE (B) <u>—</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 JULY</u> , 19 <u>49</u> , to <u>19 MAY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>19 MAY</u> , 19 <u>55</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Halter E. Hunby Jr.</u>		ADDRESS <u>M.D. Cambridge, Dorch.</u>		DATE SIGNED <u>M.D.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-27-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-27-55</u>		REGISTRAR'S SIGNATURE <u>John M. ... M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1965

BUREAU V. S.

4674

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04595

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dorchester
CITY (If outside corporate limits, write RURAL or and give nearest town) 13 Cambridge	LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 13 Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 67 Cambridge-Md. Hospital	STREET ADDRESS (If rural give location) 151 Washington Street		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
STANDIFER ASKINS		May 27, 1955	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: May 18, 1955
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
yrs. 8		Months 8	Days 8
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Cambridge, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Robert Scoggins	
14. MOTHER'S MAIDEN NAME: Geraldine Allen		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) None	
16. SOCIAL SECURITY No. None		17. INFORMANT & ADDRESS: Geraldine Allen, Cambridge, Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Septicemia			18 hours +
ANTECEDENT CAUSE (S) DUE TO (B) Lobar pneumonia, bilateral			18 hours +
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Dehydration + mal nutrition			2 days +
19A. DATE OF OPERATION: 0	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY—street, office bldg, etc.)	21C. WHERE DID (City or town) (County) (State)	INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-26 , 1955, to 5-27 , 1955, that I last saw the deceased alive on 5-27 , 1955, and that death occurred at 11:45 P. M. , from the causes and on the date stated above.			
SIGNATURE Eldridge H. Wofford		M. D.	
ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/29/1955	Waugh Cemetery	Cambridge, Maryland
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 31, 1955	John Mace, M.D.	Herbert M. St. Clair, Jr.	Cambridge, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

1055242356

BUREAU V. S.

JUN 3 1955

RECEIVED

4624

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>rural Cambridge</u>		LENGTH OF STAY (in this place) <u>5 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		<u>RURAL</u> <u>22X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) <u>JOHN</u>		(Middle) <u>WILLIAM</u>		(Last) <u>BAKER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>11</u> <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>10/7/78</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Noble Baker</u>				14. MOTHER'S MAIDEN NAME: <u>Lavenia Wyatt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>unk. 9</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital records</u>							

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Chronic Myocardial degeneration with</u>		
ANTECEDENT CAUSE (S) DUE TO <u>generalized arteriosclerosis</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (B) _____		
STATING UNDERLYING CAUSE LAST. (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/9, 1954, to 5/11, 1955 that I last saw the deceased alive on 5/11, 1955, and that death occurred at 11:45 AM, from the causes and on the date stated above.

SIGNATURE <u>Thomas F. Dodge</u>	ADDRESS <u>M. D. E.S.S. Hospital, Cambridge, Md.</u>	DATE SIGNED <u>5/11/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>5-13-1955</u>	NAME OF CEMETERY OR CREMATORY <u>JERUSALEM METH. CEM.</u>
LOCATION (City, town, or county) (State) <u>PARSONSBURG, MD.</u>	DATE REC'D BY LOCAL REGISTRAR <u>5-12-55</u>	REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>
24. FUNERAL DIRECTOR <u>Thomas F. Walker</u>		ADDRESS <u>Salisbury, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 16 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04597

4605

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Cambridge (Rural)</u>	<u>Life</u>	TOWN <u>Cambridge (Rural)</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #3</u>		STREET ADDRESS (If rural give location) <u>RFD # 3</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>THOMAS E. BENNETT</u>		OF DEATH: <u>MAY 7 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>8-19-1872</u>
9. AGE last birthday <u>82</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Waterman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Fishing Indust.</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John D. Bennett</u>		14. MOTHER'S MAIDEN NAME: <u>Hester Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Susie Bennett: Cambridge RFD# 3, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary infarction</u>			<u>5 min</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerotic</u>			<u>5-6 wks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic CVD</u>			<u>yes</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March</u> , 1955, to <u>May</u> , 1955, that I last saw the deceased alive on <u>May 7</u> , 1955, and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J. Bauman</u>		ADDRESS <u>Cambridge</u> DATE SIGNED <u>5-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-9-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Sewards Cemetery</u>		LOCATION (City, town, or county) (State) <u>James, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 10, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace</u>	
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

BUREAU V. S.

MAY 11 1955

RECEIVED

MARYLAND

04598
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 111

4625

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
TOWN <u>Secretary</u>		TOWN <u>Secretary</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Minnie</u> (First) <u>Leannette</u> (Middle) <u>Coulbourne</u> (Last)		4. DATE OF DEATH <u>5/19</u> (Month) <u>1955</u> (Day) (Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>		8. DATE OF BIRTH <u>12/31/1890</u>	
9. AGE last birthday <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Jennie (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Darryl Todd, Secretary, Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>Mutastatic adenocarcinoma</u>			
(b) Antecedent cause(s) <u>source adenocarcinoma Cervix</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Blatant Cordotomy</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION <u>2/4/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma cervix</u>	
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 3/18, 1955, to 5/19, 1955, that I last saw the deceasedalive on 5/19, 1955, and that death occurred at 11:30 p.m., from the causes and on the date stated above.SIGNATURE [Signature] (Degree or title) MD ADDRESS Cambridge, Md DATE SIGNED 5/19/55

23. BURIAL, CREMATION REMOVAL (Specify)		DATE <u>5/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		LOCATION (City, town, or county) <u>East New Market, Md</u>		STATE <u>Md</u>	
DATE REC'D BY LOCAL REG <u>5-21-55</u>		REGISTRAR'S SIGNATURE <u>Elizabeth C. Smith</u>		24. FEDERAL DIRECTOR <u>Leath P. H. Hough</u>		ADDRESS <u>East New Market, Md</u>			

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 25 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4626

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04599

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Hurlock, Rural.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hurlock, Rural.</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) Mary Eliza Dennis				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 4th, 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 6th, 1909</u>	9. AGE last birthday <u>46 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Cannery, Home.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Pinckett.</u>				14. MOTHER'S MAIDEN NAME: <u>Daisy Nowbray.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-01-7913</u>		17. INFORMANT & ADDRESS: <u>Mrs Daisy Cornish, Vienna, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Generalized Corcinomatosis</u>						<u>5 hrs</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Corcinoma of Cervix</u>						<u>8-9 m</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/4</u> , 19 <u>54</u> , to <u>May 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>55</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS <u>[Signature]</u> DATE SIGNED <u>5/15/55</u> M. D. <u>[Signature]</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 7, 1955</u>		<u>Thompstontown Cemetery</u>		<u>Hurlock, Md. R.F.D.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 7 - 1955</u>		<u>Charles W. Hastings</u>		<u>J.J. Frampton & Son.</u>		<u>Federalburg, Md.</u>	

BUREAU V. S.

MAY 13 1935

RECEIVED

4606

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 04600

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>				TOWN <u>Cambridge</u>		13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural, give location) <u>Oakley Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
GERALDINE MOORE GOLIT				MAY 21 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced		8. DATE OF BIRTH: 4-27-1923	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own home		9. AGE last birthday: 32 yrs.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: <u>Ausbrey L. Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Madaline Tregoe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Ausbrey L. Moore: Cambridge, Maryland</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
824.X Immediate cause (a) <u>Fract of cervical vertebrae & lumbar vertebrae</u>				15 minutes	
Antecedent cause(s) (b) <u>Compound fract of left leg</u>				15 minutes	
Diseases or conditions, if any, giving rise to the above cause <u>Avulsion of skin & subcutaneous tissue over left hip & gluteal region</u>				15 minutes	
stating underlying cause last <u>multiple contusions, abrasions & laceration</u>				15 minutes	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>at road</u>)		21c. (City or town) (County) (State) <u>Rt # 50 Dorchester Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 21 55 1 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Jumped out of moving truck & then struck by car while lying in road</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Defed R. Maryanov</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/25/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	
LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5-24-55</u>		REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

BUREAU V. S.

MAY 31 1955

RECEIVED

04601

MARYLAND

STATE DEPARTMENT OF HEALTH

4607

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ellisville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Bethaniz</u> (First) <u>-</u> (Middle) <u>Grail</u> (Last)		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Widowed</u>	8. DATE OF BIRTH <u>6/16/1871</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
<u>Housework</u>		<u>Maryland</u>	
13. FATHER'S NAME <u>Robert Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hillier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Leon Gray, East New Market, Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>U.S.A.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420. Immediate cause (a) <u>Coronary infarction</u>			<u>2 hrs.</u>
Antecedent cause(s) (b) <u>Arteriosclerosis CVD</u>			<u>yes</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pneumonia RLL</u>			<u>1 wk</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 2, 1955</u> , to <u>May 4, 1955</u> , that I last saw the deceased alive on <u>May 4, 1955</u> , and that death occurred at <u>6:13 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. Baumann M.D.</u>		ADDRESS <u>5151 Cambridge Rd</u>	
DATE SIGNED <u>5-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Ellisville</u>	
DATE REC'D BY LOCAL REG. <u>5-12-55</u>		24. FUNERAL DIRECTOR <u>John Macmillan</u>	
REGISTRAR'S SIGNATURE <u>John Macmillan</u>		ADDRESS <u>East New Market, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 16 1955

RECEIVED

05548

MARYLAND

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elliotts</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elliotts</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Herman Douglas Hurley</u>		4. DATE OF DEATH <u>5-18</u> 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (S) <u>Married</u>	8. DATE OF BIRTH <u>7-24-1887</u> 67 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Elijah Hurley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Horseman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>453.3</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral thrombosis</u>			<u>1 hour</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Peripheral Vascular Disease</u>			<u>6 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Raynaud's Disease</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/29</u> , 19 <u>52</u> , to <u>5/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/18</u> , 19 <u>55</u> , and that death occurred at <u>11:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>W. B. Rands M.D.</u>		ADDRESS <u>Cambridge Md</u>	
23. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>		DATE <u>3/21/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Elliotts</u>		LOCATION (City, town, or county) (State) <u>Elliotts Md</u>	
DATE REC'D BY LOCAL REG. <u>5/21/55</u>		REGISTRAR'S SIGNATURE <u>Elyabeth Craft</u>	
		24. FUNERAL DIRECTOR <u>W. Luth S. Halloway</u>	
		ADDRESS <u>East New Market, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 6 1955

RECEIVED

4698

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bishops Head</u>	
LENGTH OF STAY (in this place) <u>1 day</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural give location) <u>P.O.</u>	

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>GEORGIA A. JONES</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 25 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>8-20-1876</u>
9. AGE last birthday <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Wingate</u>		14. MOTHER'S MAIDEN NAME: <u>Virginia Fallen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Miss. Jennie Jones : Bishops Head, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>		<u>2 days</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary Heart Disease</u>		<u>7 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/25/55, 1955, to 5/25, 1955, that I last saw the deceased alive on 5/25, 1955, and that death occurred at 6:40 P.M. from the causes and on the date stated above.

SIGNATURE Lauren Manganov M. D. ADDRESS Cambridge, Md DATE SIGNED 5/26/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>5-28-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
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DATE REC'D BY LOCAL REGISTRAR <u>May 28, 1955</u>	REGISTRAR'S SIGNATURE <u>John Mace m.d.</u>	24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u> <u>Cambridge, Maryland</u>	ADDRESS
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 31 1955

RECEIVED

4609

04604
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>13</u> TOWN <u>Cambridge</u>		<u>7</u> years		TOWN <u>Cambridge</u> <u>13</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>116 Locust St.</u>				STREET ADDRESS (If rural, give location) <u>116 Locust St.</u>			
3. NAME OF DECEASED: (First) <u>Francis</u>		(Middle) <u>Arthur</u>		(Last) <u>Laskowski</u>		4. DATE OF DEATH <u>May 2, 1955</u> 19	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec. 9, 1887</u>	9. AGE last birthday: <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Mgr. Unemployment Office</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Henry M. Laskowski</u>				14. MOTHER'S MAIDEN NAME: <u>Jennie Gleason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>219-03-1739</u>		17. INFORMANT & ADDRESS: <u>Edw. H. Laskowski, 116 Locust St., Cambridge</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause		(a) <u>Coronary occlusion</u>		<u>died in sleep</u>	
Antecedent cause(s)		(b) <u>DUE TO</u>			
Diseases or conditions, if any, giving rise to the above cause		(c) <u>DUE TO</u>			
stating underlying cause last					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>8</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John M. [Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>5-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>May 4, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) <u>Cambridge, Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>May 3, 1955</u>	REGISTRAR'S SIGNATURE <u>John M. [Signature]</u>	24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED

MAY 4 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4627 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04605
Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>8 weeks 3 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rural Salisbury</u> <u>22X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural, give location) <u>Pineway Route 5</u> ✓			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>Samuel</u> (Last) <u>Layfield</u>				(Month) <u>May</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH: <u>July 8, 1927</u>	9. AGE last birthday: <u>27</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Service Station attend.</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Automotive</u>		11. BIRTHPLACE (State or foreign country): <u>Delmar Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Clayton Layfield</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Layfield (maiden name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u> DUE TO						<u>1 hr.</u>	
Antecedent cause(s) (b) <u>Diabetes Mellitus</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						<u>2 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Brain Syndrome with Metabolic Disturbance</u>						<u>3 yrs.</u>	
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION: <u>C</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John Mace, Jr.</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.		DATE SIGNED <u>May 8, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-10-55</u>		NAME OF CEMETERY <u>Ledates</u>		LOCATION (City, town, or county) (State) <u>Delmar, Del. RFD</u>	
DATE REC'D BY LOCAL REG. <u>May 10, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>W. S. Spaul</u>		ADDRESS <u>Delmar, Del.</u>	

BUREAU V. S.

MAY 11 1955

RECEIVED

4610

CERTIFICATE OF DEATH

Reg. Dist. No. 116.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u> <u>Talbot</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
13 TOWN <u>Cambridge</u>	life	OR TOWN <u>Oxford</u>	20X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Passwater Convelesent Home</u>		STREET ADDRESS (If rural give location) <u>P.O.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>SARA</u> <u>C.</u> <u>LONG</u>		OF DEATH: <u>MAY</u> <u>15</u> <u>19</u> <u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>11-12-1872</u>
9. AGE last birthday		IF UNDER 1 YEAR Months Days Hours Min.	
<u>82</u> yrs.		<u>82</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Housewife</u>		<u>Own Home</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>George T. Swain</u>		<u>Mary L. Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>none</u>	
17. INFORMANT & ADDRESS:			
<u>Mrs. Irene Schult: Baltimore, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>		<u>2 days</u>	
ANTECEDENT CAUSE (B) <u>Generalized Atherosclerosis</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/14/55</u> , 19 <u>55</u> , to <u>5/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>55</u> , and that death occurred at <u>11:10</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>Lawrence Manyanov</u>		DATE SIGNED <u>5/26/55</u>	
M. D. <u>Cambridge, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>St. Carmel Cemetery</u>	
DATE THEREOF <u>5-18-1955</u>		LOCATION (City, town, or county) (State)	
<u>Baltimore, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5-18-55</u>		REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>	
		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>	
		<u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 23 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4611

CERTIFICATE OF DEATH

Reg. Dist. No. 04607

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dor.
CITY (If outside corporate limits, write RURAL and give nearest town) OR Cambridge	LENGTH OF STAY (in this place) 60 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hospital		STREET ADDRESS (If rural give location) 214 Henry Street.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Oscar	(Middle) Percy	(Last) Lyons Sr.	(Month) May (Day) 24 (Year) 1955
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Jan. 11, 1881
9. AGE last birthday 74 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Grocer, self employed		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Oxford, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Thomas Lyons		14. MOTHER'S MAIDEN NAME: Nancy Isles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: none	
17. INFORMANT & ADDRESS: Nora M. Lyons, 214 Henry St., Cambridge, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Uremia		5 days
ANTECEDENT CAUSE (S) DUE TO Cardio-Renal Vascular Disease		2 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis		3 yrs

19A. DATE OF OPERATION: no	19B. MAJOR FINDINGS OF OPERATION: no	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-17**, 19**55**, to **5-24**, 19**55**, that I last saw the deceased alive on **5-24**, 19**55**, and that death occurred at **4:30 P.** from the causes and on the date stated above.

SIGNATURE **Robert E. Mace** ADDRESS **Cambridge, Md.** DATE SIGNED **5-24-55**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 26, 1955	Greenlawn	Cambridge, Md.

DATE REC'D BY LOCAL REGISTRAR May 26, 1955	REGISTRAR'S SIGNATURE John Mace Jr. M.D.	24. FUNERAL DIRECTOR ADDRESS Kenneth R. Thomas, Cambridge, Md.
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 31 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

4612

04608

1. PLACE OF DEATH COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dor	
CITY (If outside corporate limits, write RURAL end give nearest town) TOWN Cambridge		CITY (If outside corporate limits, write RURAL end give nearest town) TOWN Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge Md Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Donald	(First) Donel	(Middle) Macer	(Last)
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	4. DATE OF DEATH (Month) May (Day) 3 (Year) 19 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. 24 Months 24 Days 24 Hours 24 Mins.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Arthur Macer		14. MOTHER'S MAIDEN NAME Alene Stanley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. --	
17. INFORMANT Mrs Alene Macer-Madison, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
762.5 Immediate cause (a) Premature Antecedent cause(s) (b) Pulmonary congestion Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Cerebral damage due to anoxemia		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Apr. 10, 1955**, to **May 3, 1955**, that I last saw the deceased alive on **May 3, 1955**, and that death occurred at **7 P.m.**, from the causes and on the date stated above.

SIGNATURE **J. Edwin Fassett** (Degree or title) ADDRESS **227 Pine St-Camb., Md** DATE SIGNED **May 4, 1955**

23. BURIAL, CREMATION REMOVAL DATE **5/5/1955** NAME OF CEMETERY OR CREMATORY **Madison Cemetery** LOCATION (City, town, or county) (State) **Madison, Maryland**

DATE REC'D BY LOCAL REG. **May 5, 1955** REGISTRAR'S SIGNATURE **John Macer Jr. M.D.** 24. FUNERAL DIRECTOR **Herbert M. St. Clair, Jr., Cambridge, Md.** ADDRESS

2045271332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04609

4613

CERTIFICATE OF DEATH

Reg. Dist. No. 1.6

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
TOWN <u>Cambridge</u>		TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hospital</u>		STREET ADDRESS (If rural, give location) <u>8 Wright Street</u>	
3. NAME OF DECEASED (First) <u>Tavis</u> (Middle) <u>Laverne</u> (Last) <u>Matthews</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>- - -</u>	8. DATE OF BIRTH <u>Apr-19-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	9. AGE last birthday <u>15</u> yrs. If under 1 year Months <u>15</u> If under 24 hrs. Hours <u>15</u> Min. <u>15</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Reginald Sharp</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Matthews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>- - -</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Mildred Matthews- 8 Wright St Cambridge, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

763.0 Immediate cause (a) Inanition

Antecedent cause(s) (b) Bronchopneumonia

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 2, 1955, to May 3, 1955, that I last saw the deceased alive on May 3, 1955, and that death occurred at 12:50A m., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

J. EDWIN FASSETT, M.D.-227 Pine St-Camb., Md.-May 4, 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/5/1955</u>	NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>	LOCATION (City, town, or county) <u>Cambridge, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 5, 1955</u>	REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>	24. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr.</u>	ADDRESS <u>Cambridge, Md.</u>	

2045202435

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

MAY 9 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Dorchester</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Talbot</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>13 Cambridge</i>	LENGTH OF STAY (in this place) <i>3 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>20 X - 2 Trappe</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Newburne Convales Home</i>	STREET ADDRESS (If rural give location) <i>Trappe</i>		
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
<i>William R. Mc Guffin</i>		<i>May 30 19 55</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH: <i>July 8, 1888</i>
9. AGE last birthday: <i>66</i> yrs.		10. UNDER 1 YEAR: <i>Months</i> <i>Days</i> <i>Hours</i> <i>Min.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. <i>Retired</i>)		10B. KIND OF BUSINESS OR INDUSTRY: <i>Command artist</i>	
11. BIRTHPLACE (State or foreign country): <i>Balt</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME: <i>Wm. R. Mc Guffin</i>		14. MOTHER'S MAIDEN NAME: <i>Hellie Kultz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>208-03-1536-A</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Hellie Mc Guffin</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>420.0</i> <i>Stroke</i> <i>Cerebral Occlusion</i>			
ANTECEDENT CAUSE (S) DUE TO <i>Parkinson's Disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Arterio sclerotic Heart Disease</i>			
STATING UNDERLYING CAUSE LAST. (C) <i>?</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>5/27, 1955</i> to <i>5/30, 1955</i> that I last saw the deceased alive on <i>5/30, 1955</i> , and that death occurred at <i>7:40 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Lawrence Maryanow</i>		ADDRESS <i>M.D. Cambridge, Md</i> DATE SIGNED <i>6/2/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		DATE THEREOF <i>6-1-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cem.</i>		LOCATION (City, town, or county) (State) <i>Easton Talbot Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6-1-55</i>		REGISTRAR'S SIGNATURE <i>John Mace M.D.</i>	
24. FUNERAL DIRECTOR <i>Therence & Newman</i>		ADDRESS <i>Don</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 9 1965

RECEIVED

4614

CERTIFICATE OF DEATH

Reg. Dist. No. 416

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u> <u>Cambridge Md Hospital</u>				STREET ADDRESS (If rural give location) <u>147 Washington St</u>			
3. NAME OF DECEASED: (First) <u>Rhoda</u>		(Middle)		(Last) <u>Meekins</u>		4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>4</u> (Year) <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>May 5, 1896</u>		9. AGE last birthday: <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>29</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Abraham Lane</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Mc Namara</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY No.: <u>213-12-5899</u>		17. INFORMANT & ADDRESS: <u>Mrs. Edith Rasin, New York City, N.Y.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>420.1</u> Immediate cause (a) <u>Coronary insufficiency</u> DUE TO Antecedent causes (s) (b) <u>Myocardial infarction</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c) <u>Cardiac Decompensation</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 1955, to <u>May 4</u> , 1955, that I last saw the deceased alive on <u>May 4</u> , 1955, and that death occurred at <u>from the causes and on the date stated above.</u> SIGNATURE <u>John M. St. Clair, Jr.</u> ADDRESS <u>DATE SIGNED</u> <u>J. EDWIN FASSETT, M.D. - 227 Pine St - Cambridge, Md. - May 5, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/8/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 5, 1955</u>		REGISTRAR'S SIGNATURE <u>John M. St. Clair, Jr.</u>		24. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 9 1955

RECEIVED

4628

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

COUNTY Dorchester MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cambridge LENGTH OF STAY (in this place) 1 yr 5 mo 12 da
 TOWN Cambridge
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital Route # 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Ocean City
 OR TOWN 23X-2
 STREET ADDRESS (If rural give location) Route # 1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

SamuelNichols

4. DATE OF DEATH:

(Month)

(Day)

(Year)

May61955

5. SEX:

5. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X
 Immediate cause

(a)

DUE TO

Antecedent cause(s)
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Nov 24, 1953, to May 6, 1955, that I last saw the deceased

alive on May 6, 1955, and that death occurred at 9:25 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED

MAY 10 1955

BUREAU V. S.

4629

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cambridge (Rural)</u>		life		OR TOWN <u>Cambridge (Rural)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>(Cornersville RFD#3)</u>				STREET ADDRESS (If rural give location) <u>(Cornersville RFD#3)</u>			
3. NAME OF DECEASED: (First) <u>MARY</u>		(Middle) <u>E.</u>		(Last) <u>NORTH</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 27 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>1-7-1863</u>	
				9. AGE last birthday <u>92</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John N. North</u>				14. MOTHER'S MAIDEN NAME: <u>Jane B. Frazier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>Milton North: Cambridge RFD#3 Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma Desc. Colon</u>						1 year	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerotic CVR Disease</u>						5 yr	
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-20</u> , 19 <u>46</u> , to <u>5-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Eldridge H. W. Jeff</u>				M. D.		ADDRESS DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-30-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-30-55</u>		REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 3 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04614

4615

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cambridge</u> TOWN <u>Cambridge</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Med Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>DORCHESTER</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>MURLOCK</u> TOWN <u>X</u> STREET ADDRESS (If rural, give location) <u>WEBSTER ST</u>	
3. NAME OF DECEASED (Type or Print) <u>ALICE</u> (First) <u>JANE</u> (Middle) <u>PHILLIPS</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec 19, 1906</u>
9. AGE last birthday <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>ARTHUR ESKRIDGE</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE WHEATLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>180-160-112</u>	
17. INFORMANT AND ADDRESS <u>HERMAS PHILLIPS</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42011 Immediate cause (a) Coronary occlusion

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Hypertension, essential

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 12, 1953, to May 15, 1955, that I last saw the deceased alive on May 18, 1955, and that death occurred at 6:05 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Alfred R. MaryanorM.D.136 Race St, Cambridge5/19/5523. BURIAL CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 22, 1955 John Maw. M.D.Paul J. Smith, Hagerstown, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 26 1955

BUREAU V. S.

4616

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>				OR TOWN <u>Bishops Head</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Appleby Avenue</u>				STREET ADDRESS (If rural give location) <u>P.O.</u> 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
ADA MEREDITH PRITCHEST				MAY 24 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
Female	White	Widowed	1-9-1895	60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Millard Meredith</u>				14. MOTHER'S MAIDEN NAME: <u>Georgia Parks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Marcella Tolley : Fishing Creek, Md.</u>		
15 no							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
434.1							
IMMEDIATE CAUSE			(A) <u>C. ON GASTRIC HEART FAILURE</u>				1 YEAR
ANTECEDENT CAUSE (S)			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) —				
			(C) —				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>30 JAN, 1955</u> , to <u>24 MAY, 1955</u> , that I last saw the deceased alive on <u>24 MAY, 1955</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Halter E. Hunsby Jr.</u>			ADDRESS <u>M.D. Cambridge Md.</u>		DATE SIGNED <u>26 MAY 1955</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-27-1955</u>		<u>Dorchester Memorial Park</u>		<u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 27, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 31 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04616

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>X</u> TOWN <u>Cambridge (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge (Rural)</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD# 3</u>		STREET ADDRESS (If rural give location) <u>RFD # 3</u>	
3. NAME OF DECEASED (First) <u>W.</u>	(Middle) <u>RUSSELL</u>	(Last) <u>SEWARD</u>	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>11</u> (Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-24-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own General Farm</u>	9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Seward</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Rumbley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-34-7768</u>	
17. INFORMANT <u>Mrs. Anita N. Seward: Cambridge RFD# 3., Md.</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
154X Immediate cause (a) <u>metastatic carcinoma of lymph glands. Spread to brain</u>			<u>1 month</u>
Antecedent cause(s) (b) <u>carcinoma of rectum</u>			<u>1 1/2 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>July 1 - 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Rectum sigmoid</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>no</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> <u>no</u>	
HOW DID INJURY OCCUR? <u>no</u>			
22. I hereby certify that I attended the deceased from <u>Aug 15</u> , 19 <u>54</u> , to <u>May 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 10</u> , 19 <u>55</u> , and that death occurred at <u>3 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>John Mace Jr. M.D.</u>		ADDRESS <u>Cambridge Md</u>	
DATE SIGNED <u>May 14 1955</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>5-13-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>May 14, 1955 John Mace Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>	
		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 81

MAY 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04617

4631

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		STATE Maryland		COUNTY Talbot			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Cambridge		7/21/54		TOWN St. Michaels		20x - 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Lee Roland Swanhouse				May 16 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH: April 17, 1898	
				9. AGE last birthday 57 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter				10B. KIND OF BUSINESS OR INDUSTRY: Construction		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME: William Swanhouse				14. MOTHER'S MAIDEN NAME: Elizabeth (last name unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unknown WAR II				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT & ADDRESS: Eastern Shore State Hospital Records							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Bronchopneumonia						2 days	
ANTECEDENT CAUSE (B) Carcinoma of the pelvis with Metastasis						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (307x) Psychosis due to Alcohol							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						18 months	
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/21 , 19 54 , to 5/16 , 19 55 that I last saw the deceased alive on 5/16 , 19 55 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
SIGNATURE Robert H. Reddick		ADDRESS Cambridge, Maryland		DATE SIGNED May 16, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 18, 1955		NAME OF CEMETERY OR CREMATORY Christ Cemetery		LOCATION (City, town, or county) St. Michaels, Md	
DATE REC'D BY LOCAL REGISTRAR May 18, 1955		REGISTRAR'S SIGNATURE John M. M.D.		24. FUNERAL DIRECTOR St. Michaels		ADDRESS St. Michaels, Md	

RECEIVED

MAY 20 1955

BUREAU V. 2

4617

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>13</u> <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u> <u>211 Willis Street</u>				STREET ADDRESS (If rural give location) <u>1</u> <u>211 Willis Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
DECEASED: (Type or Print) <u>ETHEL TYLER TALL</u>		DATE OF DEATH: <u>MAY 24 19 55</u>					
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>3-29-1898</u>	9. AGE last birthday: <u>57</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Harry Tyler</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Wallace</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no 3</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-24-2677</u>		17. INFORMANT & ADDRESS: <u>Mrs. Reginald Brooks: Cambridge, Maryland</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>193.X</u>							
IMMEDIATE CAUSE (A) <u>Glioma - (Brain tumor)</u>							<u>2 mos</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>3</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Glioma - Rt. Frontal lobe</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>Autopsy</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-19-55</u> , to <u>5-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-24-55</u> , 19 <u>55</u> , and that death occurred at <u>8:50</u> A M, from the causes and on the date stated above.							
SIGNATURE <u>W. Bannmann</u>		M. D. <u>Cambridge</u>		DATE SIGNED <u>5-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-26-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 26, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 31 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4618

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04619

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN Cambridge		7 days		OR TOWN East New Market - Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
67 Cambridge - Maryland Hospital				Thompsontown			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Joshua John Wesley Thomas				May 22 1955			
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: May 18, 1902	
9. AGE last birthday 53 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer				10B. KIND OF BUSINESS OR INDUSTRY: Farm		11. BIRTHPLACE (State or foreign country): Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME: John W. Thomas				14. MOTHER'S MAIDEN NAME: Mary Jane Demby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-14-6088		17. INFORMANT & ADDRESS: Annie Thomas, East New Market, Md., RFD	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Myocardial Failure						8 hours	
ANTECEDENT CAUSE (S) (B) Coronary artery disease						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Postoperative Appendectomy						7/17/55	
19A. DATE OF OPERATION: 1/17/55		19B. MAJOR FINDINGS OF OPERATION: Retrocecal acute appendicitis Rt inguinal hernia					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/16 , 19 55 , to 5/22 , 19 55 , that I last saw the deceased alive on 5/22 , 19 55 , and that death occurred at 2:10 AM from the causes and on the date stated above.							
SIGNATURE W. J. Frank		M. D. Cambridge Md		DATE SIGNED 5/24/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 25, 1955		NAME OF CEMETERY OR CREMATORY Thompsontown Cemetery		LOCATION (City, town, or county) (State) Near East New Market, Md.	
DATE REC'D BY LOCAL REGISTRAR May 25, 1955		REGISTRAR'S SIGNATURE John M. [illegible]		24. FUNERAL DIRECTOR ADDRESS J.J. Frampton and Son, Federalsburg, Md.			

BUREAU V. S.

MAY 31 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04640

4632

CERTIFICATE OF DEATH

Reg. Dist. No. 113

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Golden Hill</u>		LENGTH OF STAY (in this place) <u>40 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Golden Hill</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) (First) <u>Amos</u> (Middle) <u>H.</u> (Last) <u>Travers</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 14</u> 19 <u>55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Neep</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>May 12 1888</u>	9. AGE last birthday <u>67</u> <u>57</u> <u>yes</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Sea Food</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Jacob Travers</u>				14. MOTHER'S MAIDEN NAME: <u>Mary M. Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4</u>				16. SOCIAL SECURITY NO. <u>213-24-4445</u>		17. INFORMANT & ADDRESS: <u>Christina Ellis, Cambr. dge Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Diabetic Mellitus</u>						1 month	
ANTECEDENT CAUSE (B) <u>—</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>home</u>							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 5</u> , 1955, to <u>May 14</u> , 1955 that I last saw the deceased alive on <u>May 14</u> , 1955, and that death occurred at <u>9: P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Amos W. Meade</u>				ADDRESS <u>Fishing Creek, Md</u>		DATE SIGNED <u>5/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/20/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Taylor's Island</u>		LOCATION (City, town, or county) (State) <u>Taylor's Island, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 16/55</u>		REGISTRAR'S SIGNATURE <u>Amos W. Meade</u>		24. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr.</u>		ADDRESS <u>Cambridge Md</u>	

RECEIVED
MAY 19 1955
BUREAU W. S.

4619

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge		LENGTH OF STAY (in this place) Life		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge		13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 618 High Street				STREET ADDRESS (if rural give location) Fairmount Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) LEONARD L TYLER				4. DATE (Month) (Day) (Year) OF DEATH: May 26, 1955			
5. SEX: Male		6. COLOR OR RACE: Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: March 23, 1881	
9. AGE last birthday: 74 yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Mln.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Restaurant		11. BIRTHPLACE (State or foreign country): Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Tyler				14. MOTHER'S MAIDEN NAME: Mattie St. Clair			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): 9		16. SOCIAL SECURITY NO.: 214-07-7821		17. INFORMANT & ADDRESS: Oree S. Tyler, Cambridge, Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Broncho-esophageal fistula						10 days	
ANTECEDENT CAUSE (B) Ca oesophagus						10 mo	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) Starvation						2 mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953 , to May 26, 1955 , that I last saw the deceased alive on May 25, 1955 , and that death occurred at 6 A.M. from the causes and on the date stated above.							
SIGNATURE James W. Thompson				ADDRESS Cambridge, Md		DATE SIGNED May 30, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5/30/1955		NAME OF CEMETERY OR CREMATORY Waugh Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR May 30, 1955		REGISTRAR'S SIGNATURE John Mace, Jr. M.D.		24. FUNERAL DIRECTOR Herbert M. St. Clair, Jr.		ADDRESS Cambridge, Md	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 2 1965

RECEIVED

CERTIFICATE OF DEATH

04622
Reg. Dist. No. 116

4633

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Cambridge</u> 1441 9706		STATE <u>Maryland</u> COUNTY <u>Somerset</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crisfield</u> 19X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>State Hospital</u>		STREET ADDRESS (If rural give location) <u>P.F.D.-1</u>					
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mary Elizabeth Tyler</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>May 6 1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>		8. DATE OF BIRTH: <u>July 4 1901</u>	
9. AGE last birthday: <u>53</u> yrs.		10. UNDER 1 YEAR		11. UNDER 24 Hrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unk</u>				14. MOTHER'S MAIDEN NAME: <u>Unk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause <u>153X</u>				<u>Unk</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				(a) <u>Shock due to perforation of Adenocarcinoma of Ascending colon</u>			
				(b) <u>General Peritonitis</u>			
				(c) <u>Unk</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>May 6 1955</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Carcinoma Perforation Peritonitis</u>			
21. ACCIDENT (Specify) <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1953</u> , to <u>May 6, 1955</u> , that I last saw the deceased alive on <u>May 6, 1955</u> , and that death occurred at <u>10:08 PM</u> from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>Thomas D. Duke</u>		<u>M.D.</u>		<u>State Hosp. Cambridge Md</u>		<u>May 6 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 10 1955</u>		REGISTRAR'S SIGNATURE <u>John Macfarlane</u>		24. FUNERAL DIRECTOR <u>Bradshaw & Sons</u>		ADDRESS <u>531 Main Street Crisfield, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 11 1955

RECEIVED

4620

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>	
13 TOWN <u>Cambridge</u>		20.40-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
ANN B. VALLIANT		MAY 28 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Female	White	Divorced	1-21-1869
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS	
86 yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
Domestic		Own Home	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Delaware		U.S.A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Thomas S. Sutcliffe		Susan Holding	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		none	
17. INFORMANT & ADDRESS:			
W. Enos Valliant: Cambridge, Maryland			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		30 SEC.	
465X IMMEDIATE CAUSE (A) PULMONARY EMBOLISM			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
0			
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8 APR 1955, to 28 MAY 1955, that I last saw the deceased alive on 27 MAY 1955 and that death occurred at 9:30 A.M., from the causes and on the date stated above.			
SIGNATURE <u>Hetty E. Quincy Jr</u>		ADDRESS <u>Cambridge 2nd. Dorch. County</u>	
DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Church Hill Cemetery	
DATE THEREOF		LOCATION (City, town, or county) (State)	
5-30-1955		Church Hill, Maryland	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
5-30-55		LeCompte Funeral Service Cambridge, Maryland	

MARGIN RESERVED FOR BINDING

RECEIVED

JUN 2 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04624

4621

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>13</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>400 Willis Street</u>	STREET ADDRESS (If rural give location) <u>400 Willis Street</u>		
3. NAME OF DECEASED: (First) <u>NETTIE</u> (Middle) <u>HORSEMAN</u> (Last) <u>VANE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY</u> <u>24</u> <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>6-8-1866</u>
9. AGE last birthday <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>1</u>	IF UNDER 24 HRS. Days <u>1</u> Hours <u>1</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Levin Wroten</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary E. Wroten</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>4410 Groveland Aven</u> <u>George F. Vane E Baltimore, Maryland</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>			<u>1 day</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/23</u> , 19 <u>55</u> , to <u>5/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>55</u> , and that death occurred at <u>11 15</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>Arthur R. Maryanov</u>		ADDRESS <u>136 Race St, Cambridge</u>	
DATE SIGNED <u>5/26/55</u>		M.D. <u>136 Race St, Cambridge</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-27-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 27, 1955</u>		REGISTRAR'S SIGNATURE <u>John M. Lee Jr. M.D.</u>	
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

BUREAU V. S.

MAY 31 1955

RECEIVED

4622

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
13 TOWN <u>Cambridge</u>		7 weeks		TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
67 <u>Cambridge Maryland Hospital</u>				RFD # 3			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
J. HILLERY WINGATE				MAY 4 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	11-28-1875	80 7/8 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Waterman		Fishing Indust.		Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Joseph E. Wingate				Laura Fallen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
Unknown		none		Mr. Frank Wingate, Cambridge, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) DUE TO						Congestive Heart Failure 7 wks	
ANTECEDENT CAUSE (S) (B) DUE TO						Coronary Infarction 7 wks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						Arteriosclerotic C.V.D. yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?			
		M. at work at work					
22. I hereby certify that I attended the deceased from March, 1955, to May 4, 1955, that I last saw the deceased alive on May 4, 1955, and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
W. Baumann		Cambridge		5-5-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5-6-1955		Dorchester Memorial Parks		Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 10, 1955		John Macd. Jr. M.D.		LeCompte Funeral Service		Cambridge, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 11 1955

RECEIVED

4623

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
13 TOWN <u>Cambridge</u>		6 months		13 TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Travers Street</u>				STREET ADDRESS (If rural give location) <u>7 Travers Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>B ESSIE WARNER WOLF</u>				OF DEATH: <u>MAY 5 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>2-16-1897</u>	<u>58</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Terre Haute, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Warner</u>				14. MOTHER'S MAIDEN NAME: <u>Not Known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Dr. Joseph Wolf: Cambridge, Maryland</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>				<u>Coronary Thrombosis -</u>			
ANTECEDENT CAUSE (S)				DUE TO (A)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO (B)			
				DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/4/55</u> , to <u>5/5/55</u> , that I last saw the deceased alive on <u>5/4</u> 19 <u>55</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Cecil B. Bunker</u>		M.D. <u>Cambridge Md.</u>		DATE SIGNED <u>5/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-7-1955</u>		<u>Dorchester Memorial Park</u>		<u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 10, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. B.H.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 11 1955
BUREAU V. S.